

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of ARM)	NOTICE OF PUBLIC HEARING
37.82.101, 37.82.407, and 37.82.701)	ON PROPOSED AMENDMENT
pertaining to Medicaid assistance)	
)	

TO: All Interested Persons

1. On February 5, 2007, at 1:30 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on January 22, 2007, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; e-mail dphhslegal@mt.gov.

2. The rules as proposed to be amended provide as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.82.101 MEDICAL ASSISTANCE, PURPOSE, AND INCORPORATION OF POLICY MANUALS (1) Subject to applicable state and federal laws, regulations and rules, the Montana Medicaid program pays for covered medically necessary services for persons determined eligible by the department or its agents.

(2) The department adopts and incorporates by reference the state policy manuals, namely the Family Medicaid Manual and the ~~Aged/Blind~~ Aged Blind Disabled (ABD) Medicaid Manual ~~manuals~~ governing the administration of the Medicaid program dated ~~July 1, 2006~~ January 1, 2007. The Family Medicaid Manual, the ABD Medicaid Manual, and the proposed manual updates are available for public viewing at each local Office of Public Assistance or at the Department of Public Health and Human Services, Human and Community Services Division, 111 Jackson Street, Fifth Floor, P.O. Box 202925, Helena, MT 59601-2925. The proposed manual updates are also available on the department's web site at www.dphhs.mt.gov/legalresources/proposedmanualchange.shtml.

AUTH: 53-2-201, 53-6-113, MCA

IMP: 53-6-101, 53-6-131, 53-6-141, MCA

37.82.407 LIMITATION ON THE FINANCIAL RESPONSIBILITY OF

RELATIVES ~~(1) Except as provided in (2), only the income and resources of a spouse or, if the individual is an individual who is under age 21 or blind or disabled, of a natural or adoptive parent or, if specifically provided for in subchapters 7, 9, 11 and 13, of a stepparent will be considered available to an individual in determining his eligibility for medicaid. The income and resources of any other relative will not be considered available to the individual.~~

~~(2) In the case of an individual applying for or receiving AFDC-related medicaid in the FAIM project, the income and resources of every person included in the same assistance unit as the individual as required by ARM 46.18.113 are considered available to the individual, regardless of whether the income and resources are actually contributed to the individual. Persons whose income and resources are considered available to the individual include, but are not limited to:~~

~~(a) Stepparents of a dependent child as defined in ARM 46.18.103.~~

~~(b) Siblings, stepsiblings or half-siblings of a dependent child as defined in ARM 46.18.103.~~

~~(3) Reimbursement for amounts paid by the department for medical services provided to an individual will be collected only from a spouse or, if the individual is under age 21 or blind or disabled, from a natural or adoptive parent. Reimbursement will not be obtained from any other relative.~~

(1) The income and resources of the following relatives are considered available to an individual in determining the individual's eligibility for Aged Blind Disabled (ABD) Medicaid:

(a) the spouse of the individual, except as provided in (3); and

(b) the biological or adoptive parent or parents or stepparent of the individual with whom the individual resides, if the individual is under the age of 18.

(2) The income and resources of the following relatives are considered available to an individual in determining the individual's eligibility for family Medicaid:

(a) the spouse of the individual, except as provided in (3);

(b) the biological or adoptive parent or parents or stepparent of the individual with whom the individual resides, if the individual is under the age of 19;

(c) for an individual applying for or receiving Medicaid under the child-under age six, child-age six to 19, child-medically needy or family-medically needy coverage groups only, the individual's siblings, half-siblings, or step siblings if the individual chooses to have such siblings included in the filing unit; and

(d) for an individual applying for or receiving Medicaid under any of the coverage groups described in 42 U.S.C. 1396r-6 and 42 U.S.C. 1396u-1, all siblings, half siblings, and step siblings of the individual with whom the individual resides, if the individual is under the age of 19. The individual does not have the option of excluding any such siblings from the filing unit.

(3) The following rules apply In the case of a married individual who is not living with his or her spouse:

(a) In determining the eligibility of an institutionalized spouse as defined in ARM 37.82.1330, resources of the institutionalized spouse's spouse, that is, of the community spouse as defined in ARM 37.82.1330, are considered available to the institutionalized spouse, and a resource assessment must be conducted as provided in ARM 37.82.1331, regardless of whether the institutionalized spouse and the community spouse live together or have ever lived together. In determining the

eligibility of an institutionalized spouse the income of the community spouse will be considered as provided in 42 U.S.C. 1396r-5 pertaining to the treatment of income and resources for institutionalized spouses which is adopted and incorporated by reference.

(b) In determining the eligibility of any individual who is not an institutionalized spouse as defined in ARM 37.82.1330, the income and resources of the individual's spouse are considered available to the individual as long as the spouses live together. If the individual and the individual's spouse cease living together, the income and resources of the individual's spouse are not considered available to the individual unless actually contributed to the individual beginning in the first month after the month in which the individual and the individual's spouse ceased living together. If the individual and individual's spouse never lived together, the spouse's income and resources are not considered available to the individual unless actually contributed to the individual.

(4) Except as provided in (1), (2), and (3), the department may not consider the income or resources of any relative to be available to an individual in determining the individual's eligibility for Medicaid unless:

(a) the income or resource are actually contributed to the individual; or

(b) a relative makes a vendor payment on behalf of the individual and the vendor payment would be countable income to the individual as provided in the ABD Medicaid Manual or Family Medicaid Manual that is incorporated by reference in ARM 37.82.101.

AUTH: 53-6-113, MCA

IMP: 53-6-113, 53-6-131, MCA

37.82.701 GROUPS COVERED, NONINSTITUTIONALIZED FAMILIES AND CHILDREN (1) Medicaid will be provided to:

(a) through (g)(i) remain the same.

(h) a child who has attained age six but has not yet reached age 19, whose family income does not exceed 100% of the federal poverty guidelines and whose countable resources do not exceed \$15,000. This coverage group is known as the "child-age six to 19 group";

(h)(i) through (3) remain the same.

AUTH: 53-4-212, 53-6-113, MCA

IMP: 53-4-231, 53-6-101, 53-6-131, 53-6-134, MCA

3. The Montana Medicaid program is a joint federal-state program that pays medical expenses for eligible low-income individuals. To qualify for the Montana Medicaid program, an individual must meet the eligibility requirements set forth in ARM Title 37, chapter 82. Additionally, the Family Medicaid Manual and the Aged Blind Disabled (ABD) Medicaid Manual set forth information about the eligibility requirements for Medicaid that is more detailed than that in administrative rules. These state policy manuals are published by the department to provide guidance to employees of the local offices of public assistance who determine eligibility for Medicaid.

ARM 37.82.101 adopts and incorporates by reference the Medicaid policy manuals. By incorporating these manuals into the administrative rules, the department gives interested parties and the public general notice and an opportunity to comment on policies governing Medicaid eligibility. Additionally, as a result of the incorporation of the manuals into the administrative rules, the policies contained in the Family Medicaid Manual and the ABD Medicaid Manual have the force of law in case of litigation between the department and a Medicaid applicant or recipient concerning the applicant or recipient's eligibility for Medicaid.

ARM 37.82.101 currently adopts and incorporates by reference the Medicaid policy manuals dated July 1, 2006. The department proposes to make some revisions to its Medicaid policy manuals that will take effect on January 1, 2007. The proposed amendment to ARM 37.82.101 is necessary in order to incorporate into the Administrative Rules of Montana the revised sections of the policy manuals and to permit all interested parties to comment on the department's policies and to offer suggested changes. It is estimated that changes to the Family Medicaid and ABD Medicaid Manuals could affect 82,147 Medicaid recipients. Manuals and draft manual material are available for review in each local Office of Public Assistance and on the department's web site at www.dphhs.mt.gov. Following is a brief overview of the changes being made to the Family Medicaid Manual and the ABD Medicaid Manual.

Family Medicaid Manual

No substantive changes are being made to the Family Medicaid Manual at this time. The only changes are minor policy clarifications and minor changes to procedures followed by the offices of public assistance. Thus, the revisions to the Family Medicaid Manual will have no fiscal impact.

Aged, Blind and Disabled (ABD) Medicaid Manual

MA 201-1 SSI Cash Recipients – Section 201-1 states that an individual who is eligible for Supplemental Security Income (SSI) cash assistance is entitled to receive Medicaid benefits by virtue of the individual's receipt of SSI benefits. The individual is automatically entitled to Medicaid coverage beginning in the month prior to the month in which the individual first starts to receive SSI benefits. The individual may also receive retroactive Medicaid benefits for up to three months prior to the month in which the application for SSI benefits was filed but will receive retroactive coverage for a month only if the individual has unpaid medical bills for that month as well as meeting all SSI eligibility criteria for that month.

Section 201-1 further provides that retroactive Medicaid coverage is provided only if it is requested by the individual or the individual's representative or by a real party in interest, such as a medical provider who furnished services to the individual during the months for which Medicaid coverage is potentially available. Section 201-1 currently does not specify any time limit for requesting retroactive Medicaid coverage

based on approval of an SSI application. The department is now proposing to revise Section 201-1 to state that a request for retroactive coverage must be made no later than 90 days from the date on which the individual is notified that Medicaid coverage has been approved.

It is necessary to impose a time limit on requests for retroactive coverage because the lack of time limits has caused billing problems for providers and difficulties for processing by the department. All other Medicaid coverage groups have time limitations for requesting retroactive coverage. The department proposes a 90 day limit in order to allow adequate time for communication between the recipient and providers after Medicaid coverage is approved so that it can be determined whether unpaid medical bills exist for the three months prior to the month of SSI application. Fiscal impact of this change is expected to be a reduction of less than \$10,000 in General Fund spending and a total reduction of \$37,037 in total Medicaid expenditures.

MA 402-1 Countable & Excluded Resources – When a Medicaid applicant or recipient is selling property under a contract-for-deed, the contract-for-deed is not counted as a resource in determining the applicant or recipient's eligibility if the terms of the contract require the purchaser to make annual payments to the applicant or recipient and the terms of the contract are being complied with. This section has been updated to add an additional requirement that to be excluded as a resource a contract-for-deed must provide that upon the death of the applicant or recipient the remaining payments will be made to the State of Montana. This change is required because the estates of Medicaid recipients often are not probated, and the department therefore cannot recover Medicaid payments it has made on the recipient's behalf from the recipient's estate. By requiring that contracts-for-deed contain this provision in order to be excluded, the department will be able to recover at least part of the amount Medicaid has paid for the recipient after the recipient's death. Fiscal impact is expected to be recovery of approximately \$5000 per year of Medicaid expenditures, \$1500 of which is General Fund.

MA 404-2 Penalty Periods for Asset Transfers – The average cost of nursing home care in Montana is used to calculate penalty periods for uncompensated asset transfers made by nursing home and Home and Community Based Services waiver recipients. The use of this average cost is mandated by 42 USC 1396p. This average cost is recalculated annually. The average is now being changed to reflect the results of the most recent survey of private nursing home rates in Montana, as conducted by the department's Senior and Long Term Care Division. The updated average is \$4512 per month, increased from \$4292 in 2006. The increase in the amount of the fiscal impact of this change is expected to increase costs by approximately \$56,000 annually in total Medicaid expenditures, of which approximately \$16,800 is General Fund.

MA 702-2 Cash Option Refund – When a Medicaid recipient has chosen the cash option method of meeting his or her medically needy incurment, but later believes that the cost of medical services used during the month of coverage was less than

the cash option payment made, he or she may request a refund of the cash option payment. This section has been changed to add a limit to the time period for requesting a cash option payment. Cash option payments based on a recipient's request will be limited to the 36 months immediately preceding the month of the request for refund. This change is required to attach reasonable limits on the length of time for cash option refunds and will prevent refunds from reaching across many fiscal years. Fiscal impact of this change is anticipated to be a reduction in costs of less than \$15,000 annually in total Medicaid funds, and \$4500 in General Fund.

MA 703-1 Medical Expense Option -- Medicaid applicants and recipients who have income over the categorically needy income standard must meet an incurment, which is similar to a health insurance deductible, in order to qualify for Medicaid coverage. This section explains the limitations on medical bills that can be used to satisfy the incurment. The section is being changed to allow only incurred bills payable to the provider and not to a third party, such as a credit card or other financing company. Once a bill has been paid in full to the provider, it has changed form and is no longer an outstanding medical bill, but rather a bill owed to a financing company or financial institution. Interest charged on an unpaid medical expense cannot be used to satisfy an incurment. Fiscal impact of this change is anticipated to be a reduction in Medicaid costs of less than \$3000 in total Medicaid fund annually, of which \$900 is General Fund.

MA 904-2 Post-Eligibility Treatment of Income for Institutionalized Spouses – This section discusses the deductions that are allowed from the income of a married institutionalized Medicaid recipient in calculating the recipient's contribution to the cost of the recipient's institutional care. The section provides that certain family members who reside with the institutionalized Medicaid recipient's spouse (known as the community spouse) and who can be claimed as the spouse's dependent for tax purposes may be entitled to an income maintenance allowance. The purpose of the income maintenance allowance is to ensure that the institutionalized recipient's family members have enough income and resources to meet their basic needs for shelter, food, and so forth.

This section has been amended to specify that this allowance is available only to family members who are not institutionalized themselves or enrolled in the Medicaid Home and Community Based Services Waiver program. These individuals are usually Medicaid recipients themselves, and the receipt of a family income maintenance allowance by these individuals only serves to increase their own Medicaid incurments. The elimination of the family income maintenance allowance for these individuals therefore makes sense because it does not benefit the individuals it is intended to help. Fiscal impact of this change is anticipated to be zero, as the agency is not aware of any situations where family income maintenance is currently being allowed for a dependent in either of these situations, nor of any past situations where the income maintenance allowance has been allowed to a dependent in either of these situations.

This section also provides that incurred medical expenses that meet certain criteria

can be deducted from a married institutionalized recipient's income in calculating the recipient's contribution to the cost of the recipient's care. This section has been amended to clarify that incurred medical expenses must be reported to the department within ten days of knowing of the expense being incurred. This is not a change in policy, because Medicaid policy already requires changes to be reported within ten days, but the manual has been revised to clarify that the time limits for change reporting apply to reporting of incurred medical expenses for nursing home residents. Fiscal impact of this change is anticipated to be zero, as this policy has been applied in the past in accordance with Medicaid change reporting policy.

MA 904-3 Post-Eligibility Treatment of Income for Institutionalized Individuals – This section discusses the deductions that are allowed from the income of an institutionalized Medicaid recipient who is not married in calculating the recipient's contribution to the cost of the recipient's institutional care. It provides that incurred medical expenses that meet certain criteria can be deducted from an institutionalized recipient's income in calculating the recipient's contribution to the cost of the recipient's care.

This section has been clarified to explain that incurred medical expenses must be reported to the department within ten days of knowing of the expense being incurred. This is not a change in policy, because Medicaid policy already requires change to be reported within ten days, but the manual has been revised to clarify that the time limits for change reporting apply to reporting of incurred medical expenses for nursing home residents. Fiscal impact of this change is anticipated to be zero, as this policy has been appropriately applied in the past.

ARM 37.82.407 specifies in what cases the income and resources of an applicant's relative will be considered in determining the applicant's eligibility for Medicaid. The rule provides that the only relatives whose income and resources can be counted are spouses, parents, and in some cases siblings. This rule was adopted in 1982 and has been amended only once, in 1996, to make minor changes in terminology. It is now necessary to amend ARM 37.82.407 to reflect changes which have occurred over the years in the policies governing treatment of relatives' income and resources. Additionally, it is necessary to amend ARM 37.82.407 to revise obsolete terminology, clarify certain ambiguities, and reorganize the rule to make it more readable.

Section (1) of the rule currently states that only the income and resources of a spouse, or, if an individual is under the age of 21 or is blind or disabled, of a natural or adoptive parent and in some instances a stepparent will be considered in determining the individual's eligibility. It is no longer accurate to state that parental income is counted until a child reaches the age of 21, however. In regard to Family Medicaid, formerly known as AFDC-related Medicaid, the states have the option of covering children through the age of 18, 19, 20, or 21. Apparently in the past the State of Montana covered children receiving this type of Medicaid until they reached the age of 21 years. Since the income and resources of parents with whom the child resides are counted for Family Medicaid, and "children" under 21 were potentially

eligible, it was necessary to provide that the income and resources of an applicant's parents was considered if the child was under the age of 21. Montana now provides Family Medicaid coverage only until children reach the age of 19, however. It is therefore necessary to amend the rule to provide that parental income and resources are counted for a child under age 19, since that is the oldest a child can be and still receive Family Medicaid.

In regard to Aged Blind Disabled (ABD) Medicaid, formerly known as Supplemental Security Income (SSI) Medicaid, parental income and resources are counted only until a person reaches the age of 18, in accordance with the rules of the SSI Cash Assistance program. Individuals who are 18 or above may be eligible for SSI Medicaid, but the income and resources of the individual's parents will not be considered in determining the individual's eligibility. It is therefore necessary to amend the rule to provide that for purposes of ABD Medicaid parental income and resources are counted for a child under age 18.

Section (1) as currently written does not accurately state the policy with regard to the counting of parental income and resources because it fails to specify that only the income and resources of a parent with whom the child resides are considered available to the child. The policy has always been to count only the income and resources of a parent with whom the child resides unless the income or resources of a noncustodial parent are actually contributed to the child. For example, if a child resides with the child's mother and the father lives elsewhere, the mother's income and resources are counted, but the father's income and resources are not counted in determining the child's eligibility unless the father pays child support or otherwise contributes some income or resources to the household in which the child resides. The rule is therefore being amended to clarify that only income and resources of a parent with whom the child resides are considered available to the child.

Additionally, section (1) as currently written does not clearly state the policy with regard to counting spousal income and resources. The rule does not specify that the income and resources of an applicant's spouse are counted only if the spouses live together, although that is the policy generally applied and has been for many years. Additionally, the rule is ambiguous and could be construed to mean that the income and resources of an applicant's spouse are not counted if the applicant is under the age of 21 or is blind or a person with a disability, although in fact it is the department's policy to count the income and resources of an applicant's spouse if they are living together, regardless of the age of the applicant or whether the applicant has a disability or is blind. The rule is therefore being amended to clarify that spousal income and resources are counted without regard to age or disability. It is also being amended to state the general rule that spousal income and resources are counted only if the spouses live together, provide an exception to the general rule, and specify when income and resources first will be counted after spouses who have been living together cease to do so.

Although the rule is being amended to clarify that, in general, spousal income and resources are counted only if the spouses live together, the rule also is being

amended to specify that income and resources of a spouse must be counted regardless of whether they are living together in the case of an institutionalized spouse who is applying for Medicaid. This provision is necessary to comply with federal "Spousal Impoverishment" provisions in 42 U.S.C. 1396r-5. In 1988 Congress enacted the Medicare Catastrophic Coverage Act of 1988 (the MCCA), which was codified in 42 U.S.C. 1396r-5. The MCCA changed the way Medicaid eligibility was determined for married persons seeking Medicaid to pay for nursing home or other institutional care.

Prior to 1988 a married couple had to spend all their resources except \$3,000 before the institutionalized spouse could qualify for Medicaid. As a result, the spouse who was not institutionalized but continued to live in the community, known as the "community spouse", had virtually no resources left to meet the community spouse's own needs. Congress therefore amended the Medicaid statute to allow the community spouse to keep more than \$3,000 in resources, in order to prevent the community spouse from being impoverished. Similarly, the MCCA contains provisions to allow the community spouse to keep enough income to provide for the community spouse's own needs.

As part of the process of determining what amount of resources the community is entitled to keep, Section 42 U.S.C. 1396r-5(c) requires that the state Medicaid agency conduct a resource assessment listing all nonexcluded resources owned by the institutionalized spouse, the community spouse, or both of them jointly. The statute requires that a resource assessment be conducted for every married applicant for Medicaid institutional coverage. It makes no exception in the case of an applicant who was living separately from the applicant's spouse prior to entering the nursing home or other institution. The department has complied with the provisions of the MCCA since the federal law took effect but has never amended ARM 37.82.407 to incorporate its requirements. Therefore, ARM 37.82.407 must now be amended to provide that the resources of an institutionalized spouse's husband or wife are always considered available to the institutionalized spouse and must always be counted in determining Medicaid eligibility and to provide that the income of the community spouse will be considered as provided in 42 U.S.C. 1396r-5.

ARM 37.82.407(2) currently makes reference to "an individual applying for or receiving AFDC-related Medicaid in the FAIM project". Family Medicaid was formerly known as AFDC-related Medicaid because families eligible for Aid to Families with Dependent Children (AFDC) Cash Assistance were automatically eligible for AFDC-related Medicaid as well. In 1996 the Temporary Assistance for Needy Families (TANF) program replaced the AFDC Cash Assistance program as a result of the passage of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA). At that time cash assistance and Medicaid coverage were "de-linked", meaning that persons receiving TANF cash assistance are not necessarily eligible for Medicaid by virtue of receiving TANF Assistance. Since TANF Cash Assistance and Medicaid are no longer linked as they formerly were, this program has been renamed Family Medicaid instead of changing the name from AFDC-

related Medicaid to TANF-related Medicaid. The FAIM project was a demonstration project implemented before the passage of PRWORA changed the rules for cash assistance to families. The reference to the FAIM project has been deleted because the project no longer exists.

In addition, ARM 37.82.407(2) currently provides that the income and resources of an applicant's siblings are considered available to the applicant in determining the applicant's eligibility for AFDC-related (now Family) Medicaid. This is no longer correct for all Family Medicaid coverage groups. It is true for Medicaid coverage groups that are comparable to the old AFDC-related Medicaid, namely Medicaid for individuals under age 19 who reside with a caretaker relative and transitional Medicaid for families who become ineligible for cash assistance because of income from employment. Sibling income and resources must be counted for these coverage groups because 42 U.S.C. 1396u-1, which was enacted as part of PRWORA, provides that eligibility for Medicaid coverage groups that are comparable to the old AFDC-related Medicaid will be determined using the income and resource methodologies used in the AFDC cash assistance program as of July 16, 1996. Thus, since sibling income and resources were counted in determining eligibility for AFDC cash assistance on July 16, 1996, they must be counted in determining eligibility for transitional Medicaid as described in 42 U.S.C. 1396r-6 and Medicaid for individuals under age 19 who reside with a caretaker relative as described in 42 U.S.C. 1396u-1.

However, the department is not required to apply the income and resource methodologies used in the old AFDC cash assistance program for the other Family Medicaid coverage groups, namely the child-under age six, child-age six to 19, child-medically needy and family-medically needy coverage groups. For these groups the department follows the more liberal policy of counting sibling income and resources only if the applicant chooses to include any or all siblings in the Medicaid filing unit. This benefits the applicant by allowing the applicant to include or exclude siblings, and hence the sibling's income and resources, depending on what is most advantageous for the applicant. If an applicant has a sibling who has little or no income and resources, it will benefit the applicant to have the sibling included in the filing unit for Medicaid because a higher income standard is used when another person is included in the filing unit. On the other hand, if a sibling has income or resources which will result in the filing unit being ineligible due to excess income or resources, the applicant may choose to exclude the sibling from the filing unit.

The amendment of ARM 37.82.407 is therefore necessary to provide that for certain Family Medicaid coverage groups the income and resources of siblings must be considered available to the applicant but for other Family Medicaid coverage groups the income and resources of siblings will be considered available only if the applicant chooses to have the sibling included in the filing unit.

Finally, ARM 37.82.407 has been reorganized to set forth the policies for ABD Medicaid and for Family Medicaid separately, since the policies are not always the same. This will make the rule easier to read and understand.

There will be no significant fiscal impact as a result of the amendment of ARM 37.82.407. Virtually all of the amendments merely reflect policy changes which are already in effect or are nonsubstantive changes to clarify policy or revise terminology. There is, however, one case where the department has been prohibited from counting the income of an ABD Medicaid recipient's spouse because of a decision by the Board of Public Assistance that ARM 37.82.407 as currently written does not permit the department to count the income of a disabled individual's spouse. When the rule is revised to clarify that spousal income is always counted if the spouses live together, regardless of the age or disability of the applicant, the spousal income of this recipient will be counted. As a result the recipient will have an incurment of approximately \$16,000 yearly, resulting in a Medicaid savings of \$16,000 per year. The savings to the General Fund will be \$4,800 per year. The amendment of the rule also will result in this recipient being ineligible for Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB) coverage, resulting in additional savings of approximately \$2,200 per year. QMB and SLMB are 100% federally funded, so there is no savings to the General Fund.

The amendment of ARM 37.82.701 is necessary to correct an error that occurred when the rule was amended in September 2006. ARM 37.82.701 describes the Family Medicaid coverage groups. Subsection (1)(h) of the rule provided that Medicaid will be provided to "a child who has attained age six but has not yet reached age 19" if certain conditions are met. When the rule was amended the word "child" was inadvertently left out, however, so subsection (1)(h) currently states that Medicaid will be provided to "a who has attained age six but has not yet reached age 19..." It is necessary to re-insert the word "child" for grammatical purposes and clarity. There is no fiscal impact to this change.

4. The department intends that the amendments to ARM 37.82.101 be applied retroactively to January 1, 2007. The department was unable to file this rule at an earlier date due to the pressing nature of other business in the Office of Legal Affairs. No detrimental effects are anticipated as a result.

5. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on February 9, 2007. Data, views, or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

6. The Office of Legal Affairs, Department of Public Health and Human Services has been designated to preside over and conduct the hearing.

/s/ Barbara Hoffmann for
Rule Reviewer

/s/ Joan Miles
Director, Public Health and
Human Services

Certified to the Secretary of State January 2, 2007.